Idaho Legislative Audits
P.O. Box 83720
Boise, ID 83720-0054
208-334-2475

Idaho Department of Health & Welfare

Management Report on Internal Control

Issued: May 19, 2006
Fiscal Year: 2005

LEGISLATIVE AUDITS' MANAGEMENT LETTER

DEPARTMENT OF HEALTH AND WELFARE

PURPOSE AND SCOPE. In planning and performing our audit of the statewide Single Audit report for the State of Idaho for the fiscal year ended June 30, 2005, we completed certain financial audit procedures on the Idaho Department of Health and Welfare's financial activities that occurred during the fiscal year. The scope of work was limited to the Department's federal major programs as determined for the statewide Single Audit. Therefore, we considered the internal control structure to determine appropriate procedures and required tests, along with procedures performed at other State agencies, that would allow us to express our opinion on the statewide Single Audit and not to provide assurance on the Department's internal control.

CONCLUSION. Although we include 13 findings and recommendations in this report, we conclude that the financial operations of the Department meet accepted standards, and that the Department substantially complies with laws, regulations, rules, grants, and contracts for which we tested compliance.

FINDINGS AND RECOMMENDATIONS. The 13 findings and recommendations presented below relate to the program indicated.

FINDING #1
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5028
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Eligibility
Questioned Costs: Not determinable

Changes are needed in the criteria used to establish Medicaid eligibility under the Katie Beckett program.

The Home Care for Certain Disabled Children (Katie Beckett) Medicaid program is authorized under section 1915(c) of the Social Security Act, and allows states to extend Medicaid eligibility to children with disabilities, who would not otherwise qualify due to parental income or other resources. These children require an institutional level of care and would qualify for Medicaid if placed in an institution. However, by waiving the income and resource requirements, these children can be cared for in their own home at a lower cost to Medicaid. The primary objective of this program is to provide the required institutional levels of care at the lowest possible cost to the Medicaid program.

Federal regulations define "institutional level of care" as those services that are inherently complex; performed or supervised by technical or professional personnel; have been ordered by a physician; and are required 24 hours per day and ordinarily furnished, as a practical matter, on an inpatient basis (42 CFR 409, 435, 440, and 483).

Federal regulation (42 CFR 435.225) also defines the criteria that states must meet when determining eligibility under the Katie Beckett

program. States can extend eligibility to children under the age of 19 "who would be eligible for Medicaid if they were in a medical institution, and who are receiving, while living at home, medical care that would be provided in a medical institution." In addition, it must be appropriate to provide this care outside such an institution, and the cost to Medicaid shall be no higher than the estimated Medicaid cost for appropriate institutional care.

In Idaho, the Katie Beckett Medicaid program is included in the Department's Medicaid State Plan, and the conditions for eligibility and other requirements are established in Administrative Rules (IDAPA 16.03.05 and 16.03.09). Although these rules generally mirror the language of the federal regulations, the Department's interpretation states that eligibility is "not dependent upon the receipt of services, but rather on whether the child needs the level of services" provided by an institution. In addition, the family may or may not choose to receive the same level of services they would receive in an institution, and they may elect to receive fewer services as long as the child can be safely and effectively served in the community. This interpretation varies from the language and intentions of federal regulations by establishing eligibility based on medical condition without regard to the delivery of required institutional levels of care while the child lives at home.

During fiscal year 2005, more than 1,600 children received Medicaid benefits under the Katie Beckett program at a cost of nearly $24 million. However, nearly one-third of these children (534) received less than $3,000 each in benefits during the year. Most of these children received limited services, such as school-based therapy and prescription drugs, or other services that were not institutional in nature. Significant periods of time existed where no services were provided at all. Allowing families to choose the type, frequency, and intensity of services is contrary to the federal criteria that the child receives the required institutional levels of care as a condition of eligibility.

No requirement exists for the Department to ensure that the required institutional level of care is provided. Cost data in the Medicaid system clearly shows that at least one-third of the current clients are not receiving institutional levels of care, and the Department has no knowledge that these services are provided, or paid for by the family. The absence of any evidence that institutional care is provided raises the likelihood that, although medically eligible for institutional care, the delivery of such care is not required, and the objectives of the Katie Beckett program are not met.

A comprehensive medical evaluation and assessment of needs is developed for all clients determined eligible for the Katie Beckett program. However, no process exists to ensure that the level of care required and ordered by a medical professional is provided.

A more thorough review is needed to determine whether the lack of

Medicaid costs for institutional care is an issue of eligibility, medical diagnosis, or the need for improved monitoring to ensure clients are receiving appropriate care paid for or provided by others.

Other states, such as Maine, have recently revised their rules, and require parents of a Katie Beckett child to provide detailed documentation of medical services provided to ensure that the child is safely and effectively served outside an institutional setting. This information could also confirm whether the determination of medical condition and eligibility was appropriate.

RECOMMENDATION #1

We recommend that the Department undertake a thorough review of the criteria used to determine eligibility in the Katie Beckett program, and establish processes to monitor services provided to clients to ensure that an appropriate level of care is provided.

CORRECTIVE ACTION PLAN

We believe that all Katie Beckett clients are eligible according to federal rules and the State plan. We disagree that the Department should monitor all services provided for Katie Beckett clients. We acknowledge however, that the number of clients could be decreased by making the criteria stricter.

We studied ten of the clients that the auditor indicated as "ineligible" and found that all were eligible based on their medical needs. The auditor's conclusion that "a third of the clients who are receiving benefits under the Katie Beckett program must not be eligible, or are not receiving necessary services, because the level of benefits paid is too low (less than $3,000 per year)" is not correct. The amount of spending is not an accurate indicator of eligibility. Nor is spending a good indicator that clients are receiving services because many parents have other means to provide the assistance needed, i.e., other programs, personal funds, personal care, and personal insurance.

The State is not required, nor has the means, to track all treatment and services provided to Katie Beckett clients, we can only track those services provided through the Katie Beckett program. There is no practical way for the Department to track services that parents provide privately.

We do however, acknowledge that the State's criteria could be made stricter in an effort to reduce the number of eligible clients. The eligibility criteria is defined in a documented "interpretation" that clearly specifies each condition and degree of severity or care needed that qualifies as "institutional level of care." The State could make criteria stricter and exclude portions of the 1,600 clients currently in the program. The audit does not provide guidance as to which criteria, if any, should be adjusted.

FINDING #2

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5048
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

Idaho is one of only two states without a certified Medicaid Fraud Control Unit.

The federal government offers a grant program (CFDA 93.775) to fund State Medicaid Fraud Control Units. The grant provides 90% federal funding for the first three years, and 75% thereafter, for investigation and prosecution of fraud and patient abuse in the State Medicaid program. The Fraud Unit must be separate and distinct from the State Medicaid agency, and must employ sufficient professional, administrative, and support staff to perform its duties and responsibilities in an effective and efficient manner.

The Department's Fraud and Investigation Unit does not meet the independence requirements to be certified and is, therefore, funded as Medicaid administrative costs at 50% federal match. In addition, no comprehensive program exists within the Department or other State agency to investigate and prosecute patient abuse issues. As of June 2005, Idaho and North Dakota are the only states without a certified Medicaid Fraud Control Unit.

Increased Funding

Moving the program to an independent entity, such as the State Attorney General's Office, would allow the program to be certified and receive five times more resources every year for the first three years, and double the current resources every year thereafter, without any additional General Funds. Total program funding could increase from $400,000 to $2,000,000 per year for the first three years and $800,000 per year thereafter, based on the current General Fund share of $200,000.

More Investigations and Recoveries

More suspected Medicaid fraud cases could be investigated and pursued, which would likely result in increased recoveries. A national report of certified units in other states for fiscal year 2003, showed that recoveries averaged more than $2 for every $1 in costs. The enhanced federal funding could also provide the resources necessary to establish a comprehensive program to seek out, investigate, and prosecute physical and financial abuses of elderly patients. Current national and local news stories about abuses of the elderly highlight the need for a program to address these issues in our State.

Other Benefits

Several other benefits result from establishing a certified Medicaid Fraud Unit. For example, an independent unit would allow investigations to proceed without any actual or perceived conflicts of interest. This would improve public confidence and ensure that investigations are resolved based on the merits of the issues.

Establishing the unit within the State Attorney General's Office would also provide a statewide platform in which to announce the efforts and results of fraud investigations and elder abuse. This public exposure would provide additional deterrence, and notify clients and providers that suspected cases of Medicaid fraud and elder abuse will be pursued.

RECOMMENDATION #2

We recommend that the Department initiate a dialog with Executive and Legislative leadership to evaluate the merits of establishing a certified Medicaid Fraud Control Unit that could provide additional funding for investigating and prosecuting suspected cases of Medicaid fraud and patient abuse. We suggest that this dialog include the State Attorney General.

CORRECTIVE ACTION PLAN

The Department recognizes the need to add additional resources for fraud

investigations. We concur with the auditor's recommendation that the Department should be a participant in any evaluation of establishing a certified Medicaid Fraud Control Unit (MFCU). However, we disagree that a MFCU would lead to financial benefit or increased investigations and recoveries. It is possible that a certified unit might be perceived as being more independent and provide more public exposure, but there is no clear evidence to support this conclusion. Moreover, the separation of fraud investigations from the Department might actually have a detrimental effect on the efficiency and effectiveness of the State's ability to timely pursue fraud, waste and abuse in its programs. The Department believes that the decision to establish an independent MFCU is a policy decision for the Legislative, the Governor's office, and Department heads.

Increase in General Fund Cost

Establishing an independent unit would result in increased costs from the General Fund. The 90% enhanced funding is essentially one time dollars to be utilized for start-up costs. These would include expenses such as vehicles, computers, software, equipment, training, or cost of developing legislation or policies and procedures. To properly evaluate the benefit of the enhanced funding we need to evaluate the cost of established units.

An independent certified unit has greater staffing requirements and costs that could not be saved or transferred from the Department or other agencies. The Department does recognize the need to add additional resources for all fraud investigatory roles for proper staffing of fraud caseloads. The Department compared the costs of properly staffing the fraud unit within the Department against the cost of placing those resources in an independent and certified unit. The analysis identified that an established certified unit in the Attorney General's Office would cost more State dollars to maintain than it would to properly staff the fraud unit within the Department.

Investigations and Recoveries

The legislative auditor states that with a certified unit, more cases would be investigated and pursued, which would likely result in increased recoveries, and that nationally, certified unit recoveries averaged more than $2 for every $1 in cost.

The Department disagrees with this assertion. The number of cases investigated is primarily related to the number of investigative resources applied. A properly staffed investigative unit has the ability to pursue a limited amount of cases regardless of where it is located.

Although the auditor correctly states that nationally certified units, on average, recovered $2 for every $1 cost, they did not mention that the costs used to compare did not include state costs, and the dollars cited as recoveries included both state and federal dollars according to the Office of Inspector General State Medicaid Fraud Control Unit Annual Report. Additionally, the national average for all states was inflated by substantial recoveries in a few states such as California, Texas and New Jersey. In fact, 9 out of 48 states accounted for all of the difference in the high recoveries to inflate the national average, and the remaining 39 state-certified units on average, broke even or recovered less than their cost of operating.

We believe there would be a loss of efficiency and possibly effectiveness for both the Department and Medicaid fraud investigations if the two were separated. During past discussions with other states relating to the effectiveness of fraud and abuse investigations, one of the key barriers identified is the relationship and communication between the state agency and the independent certified unit. Once preliminary investigations are referred to an outside entity for further investigation, it often creates a duplication of effort and reduces ability to timely respond to fraud. The current Fraud Unit works closely with other Department resources and systems such as Information Technology, Medicaid Information Systems, Surveillance and Utilization Review, Auditors, Support Staff, and Medicaid Staff, and has the ability to effect

policy changes necessary to curb fraud and abuse.

The Department believes it is a policy decision for the legislature and the Governor's Office as to where the unit should be housed. House Bill 668 to establish an independent unit in the Office of the Attorney General to investigate and prosecute Medicaid fraud was defeated in the Senate Health and Welfare Committee. The Department believes that this issue needs to be studied to determine the requirements, costs, and benefits of an independent certified fraud unit. The Department needs to be directly involved in the evaluation of a certified unit.

FINDING #3
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5028
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

The process for identifying and recording private health insurance coverage of Medicaid clients needs improvement.

Federal regulation (42 CFR 433.139) requires the Medicaid program to establish the "probable existence" of liable third parties at the time claims are paid. This follows the general concept that the Medicaid program is the "payor of last resort" when all other resources and liable third parties, including private health insurance, are exhausted. The greatest challenge in meeting this requirement is identifying health insurance that exists or becomes available while a client is eligible for Medicaid assistance.

The Department has a contract to identify Medicaid clients who have private health insurance as part of the overall third-party recovery efforts. The contractor uses a variety of processes to identify Idaho Medicaid clients who have health insurance with carriers across the nation. They also analyze provider claims that indicate other insurance has paid a portion of the costs. Claims that indicate other insurance has paid are referred to as "suspect claims."

Some insurance data known by providers is not pursued. We analyzed all claims paid during February 2005 and identified 59,628 "suspect claims" where providers indicated a payment was received from an insurance resource. We performed a simple comparison of these claims with the record of known health insurance resources, and identified 1,168 claims (749 clients) in which resources known by providers were not entered in the Automated Information Management (AIM) system. Although providers sometimes identify amounts as "other insurance" in error, several claims we examined more extensively identified insurance resources that were not entered in the AIM system.

Several reasons exist as to why other insurance data is not pursued. However, most instances result from changes in a client's insurance coverage or carrier that are not identified promptly and do not trigger a review of the suspect claim. Our review of suspect claims was performed nearly seven months after the claims were paid, and highlighted this situation. A retrospective review of suspect claims could identify new resources and reduce the delay in identifying policy changes or new insurance carriers.

Insurance resources are recorded that have little or no possibility for cost avoidance or recovery. We analyzed the nearly 82,000 insurance

resources added to the Medicaid AIM system during fiscal year 2005, and identified 489 insurance resources with coverage periods that started after the client's Medicaid eligibility had ended. Obviously, no cost avoidance or recovery could occur, since no claims were paid during the insurance coverage period. Based on the contract rate of $39 per insurance resource, the Department paid nearly $20,000 for insurance resource data that had no chance for any cost avoidance or recovery at the time it was entered.

The contract and related documents require the contractor to identify and validate insurance coverage for Medicaid-eligible recipients that can be billed. Although this process is not specifically described, the volume of resources that do not overlap client eligibility indicates the need to improve the contract definitions, processes, and monitoring of this activity.

No comprehensive data match exists with Blue Cross or Regence Blue Shield of Idaho. The contractor uses an automated "data match" process to identify Medicaid clients who have health insurance coverage. However, a comprehensive data match process does not exist with Blue Cross or Regence Blue Shield of Idaho, the two insurance companies that cover more than 75% of all Idaho citizens (based on the Idaho Department of Insurance annual report for 2004).

Blue Cross and Regence Blue Shield both provide access that allows the contractor to search for clients. However, these current processes are limited and create inefficiencies that may allow omissions to occur. An enhanced process is needed to improve the time frame and ability to identify Medicaid clients who have health insurance coverage issued by Idaho-based companies. This effort may require legislation or administrative rules to establish the Department's ability to access private health insurance data.

RECOMMENDATION #3

We recommend that the Department improve the processes and efforts to identify and record health insurance resources of Medicaid clients as follows:

1. **Develop a retrospective review process for suspect claims, in order to identify insurance resources known by providers previously excluded from the process.**
2. **Amend the contract to define a valid insurance resource as one where the coverage period overlaps the client's period of Medicaid eligibility. The Department should analyze all insurance resources added during the last year, and request a refund from the contractor for fees to add resources for clients who were not eligible during the insurance coverage period.**
3. **Coordinate the establishment of an enhanced data match process with Idaho-based private insurance companies to improve the efforts to identify Medicaid clients having health insurance. This may require the assistance of the Idaho Department of Insurance and legislation to establish the Department's ability to access this data.**

CORRECTIVE ACTION PLAN

We disagree that insurance data is not pursued. We believe that the insurance resources recorded do avoid cost or lead to recoveries. We are currently researching other state laws regarding comprehensive insurance data.

Some insurance data known by providers is not pursued. We believe that insurance data is pursued. We base this conclusion on a thorough review of ten randomly selected cases out of the 1,168 claims the auditor suspected. In all of the cases we reviewed, insurance data, if warranted, was pursued. Eight cases (80%) were pursued to the fullest extent possible. In four of the eight cases, insurance information was already recorded so additional insurance data was not needed. In two of the eight cases the only insurance was Medicaid, so additional insurance data was not needed. In one of the eight cases the claim was denied by Medicaid, so no additional insurance data was needed. In one of the eight cases the claim was electronic, which does not include the insurance name, and despite the lack of information, the contractor made efforts to obtain insurance information from both the client and doctor. Two cases (20%) were pursued but the process could be strengthened because it was later found that the insurance companies had provided incorrect information about the clients.

Insurance resources are recorded that have little or no possibility for cost avoidance or recovery. We know that some of the 489 questioned insurance records probably avoided cost or lead to recovery. We also know that some of the 489 records were not billed to the Department. It is true that some of the 489 questioned insurance records ultimately did not result in cost avoidance, but it is impossible to know which records will yield future cost avoidance and which will not. The reason that insurance records are useful for clients whose eligibility ends is because clients often return to eligibility while insurance is available. We reviewed most of the 489 entries questioned by the auditor and found many examples (more than 20%) where clients were eligible at the time insurance was added or became eligible again during the period of recorded insurance. Unfortunately, it is not possible to measure how much cost was avoided from the 489 insurance records. The Department must rely on judgment for setting the parameters for accepting and paying the contractor for insurance records. We believe that the parameters for recording insurance after eligibility ends will reasonably assure that avoided costs and recoveries will at least pay for the cost of the insurance data.

No comprehensive data match exists with Blue Cross or Blue Shield of Idaho. We agree that legislation may be required to obtain information more efficiently from some Idaho insurance administrators. The Department has been involved in researching legislation in other states in order to recommend changes.

FINDING #4
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5028
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Eligibility
Questioned Costs: Not determinable

Medicaid eligibility continues to be improperly determined, due primarily to the outdated automated system.

The prior two audit reports included issues relating to errors in determining Medicaid eligibility, and delays in processing applications and completing re-determinations of eligibility within the required time frames. Improvements were made to the processes, additional staff was authorized, and training and quality review programs were established. However, the volume of errors remains high, and the primary factor not yet addressed by the Department is the outdated automated Eligibility Program Information Computer System (EPICS) used to process and record Medicaid eligibility.

The federal grantor has provided funding to evaluate Medicaid eligibility and payment errors over the past several years, the current results of which were disclosed in the *Payment Error Rate Measurement Report* issued in October 2005. This report indicates that the error rate for determining eligibility for Medicaid has remained at 10% for the past two years. The eligibility error rate for the Children's Health Insurance Program (CHIP) has improved, but remains very high at nearly 30%. These error rates indicate that more than 20,000 clients, many of whom are ineligible for any type of Medicaid assistance, are incorrectly determined eligible.

Several reasons for payment errors were described in the report, but the cause for the high eligibility error rates was not specifically identified. Based on our tests and evaluation of the processes used to determine eligibility, we believe the EPICS system is the primary factor contributing to these high error rates.

The process for determining Medicaid eligibility requires gathering relevant data about a client, household composition, income, resources, and a variety of other factors. This data is entered into EPICS and, through various automated methods, provides management data to staff for use in determining eligibility, timing re-determinations, and generating information necessary to ensure that benefits to clients are properly calculated and supported.

EPICS works well at processing and storing data, but this system was originally developed during the early 1980's and has been extensively modified over the past 25 years. The core software and system processes do not integrate well with current technology and Web-based applications. Other factors limit the functionality and controls needed to assist staff in correctly determining eligibility and linking with other essential data sources. It is these conditions that create the opportunity for errors, and limit the efficient and effective processing of applications and eligibility determinations.

Data in EPICS is also used to support eligibility for many other benefit programs managed by the Department. This data is shared electronically with other automated systems to process payments, determine eligibility, or provide updated client information. These other programs are adversely affected by the limitations of EPICS to process data in the current automated environment.

The Department requested funding for fiscal year 2007 to replace the system; however, this was not included in the Governor's budget recommendation to the Legislature. Although some efforts can be taken with existing funding, a specific budget unit and organized project is needed to address this critical need.

RECOMMENDATION #4

We recommend that the Department identify the processes and issues that cause Medicaid eligibility to be improperly determined. Corrective action is also needed to address payment processing errors reported in the *Payment Error Rate*

Measurement Report. **We also recommend that the Department continue to seek resources to replace EPICS.**

CORRECTIVE ACTION PLAN

The Department has taken steps to improve the quality and timeliness of Medicaid eligibility determinations. Modifications have been made in the EPICS system that will allow workers to more accurately select the correct coverage group for applicants. Modifications go into effect in April 2006 to renewal processing in the automated system.

The Department has applied for, and expects approval of, a Medicaid waiver to allow all children with income below 185% of poverty to be in one benefit plan. This change to policy will virtually eliminate coverage group errors for children. This policy and other simplifications will allow workers over time to progress toward timely processing of applications and renewals for family based Medicaid.

The Idaho Legislature approved $2.1 million from the General Fund to begin replacement of the EPICS system. This money will receive federal match and allow the Department to replace the existing system over the course of the next 2 to 3 years.

FINDING #5

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5048
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not Determinable

Essential edits in the Medicaid claims payment system are disabled and allow claims to be paid in error.

Each state Medicaid program is required by Title XIX of the Social Security Act and federal regulations (42 CFR 433) to operate an automated claims processing system. These systems are generally referred to as Medicaid Management Information Systems (MMIS) and must meet strict standards for operation, as described in the *State Medicaid Manual* published by the federal grantor, Centers for Medicare and Medicaid Services (CMS).

The processing system must meet several basic procedures to ascertain that each claim includes proper information about the client, provider, type of service, and other data that ensure the claim is supported and the amount paid is accurate. Automated system edits, calculations, and comparisons are required to ensure the accuracy of claims processing to reduce or eliminate the opportunity for errors.

We analyzed claims paid from January to June 2005, and determined that several system edits that ensure the accuracy and validity of claim payments were disabled during this period. For example, the two edits that ensure each claim properly identifies the client and the provider were disabled. These edits match the names and identification numbers on the claims to the list of authorized providers and eligible clients, and are essential to ensure the accuracy of payments.

We identified nearly 500 claims paid between January and June 2005, in which client names and identification numbers did not agree to the record of eligible clients. Our limited review of 30 clients showed at least three instances in which the client actually served was incorrectly entered. In one instance, the claim was paid in error because the actual client was not eligible on the date of service.

We also noted that the edit to deny claims resulting from injuries or accidents was also disabled. This edit is intended to ensure that Medicaid is the payor of last resort, and require providers to seek payment from other liable sources. These other sources are generally casualty or liability insurance in connection with injuries sustained in a vehicle accident, or where other liability coverage may exist.

As a result, claims are paid that should be denied when other liable resources relating to injury or accident claims may exist.

RECOMMENDATION #5

We recommend that the Department enable all essential system edits to ensure the accuracy of claims paid, and ensure that Medicaid is the payor of last resort when claims relating to injuries or accidents are submitted.

CORRECTIVE ACTION PLAN

For the following reasons, we disagree that essential edits are disabled.

The edit that matches a client's name and number to Medicaid records was in test in January and February 2005, to determine the most effective way to handle mismatches. However, it was turned on March 1, 2005, and has been in place since that time. Paper claims that do not match both name and number are visually reviewed and electronic claims that do not match both name and number are automatically denied. We did not review the specific claims found by the auditor so we are unsure if they are errors. However, this edit is in place and working as intended and has been for over a year. Based on the auditor's sample, a projection of the error rate would result in a potential of 100 errors (3 errors/30 sampled, 500 claims, 6 to 12 months per year) out of 10 million claims last year (0.001%). It is very possible that the errors occurred during the test period or were mistakes in the manual process of visually comparing paper claims. Despite this low error rate, we will request a copy of each identified error and determine the cause.

The edit that checks for "injury accident" claims is active. These claims are automatically "pended" for further review except for Medicare claims which we are federally mandated to pay. It is possible that the claims questioned by the auditor were Medicare claims, which we are required to pay, or manually reviewed claims that were ultimately paid for some reason. We do not have the claims the auditor is questioning, but we will request them to determine if there were actual problems.

FINDING #6

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0205ID5028
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

The Healthy Connections Medicaid program is not cost effective for at least two of four eligibility groups.

The Healthy Connections program is a "freedom of choice" waiver under Title XIX, section 1915(b) of the Social Security Act, intended to reduce Medicaid costs by assigning clients to primary care physicians who will manage their medical needs. The general concept of this waiver program is to reduce unnecessary utilization of high-cost services such as emergency rooms, inpatient hospitalization, and specialists, without adversely affecting the quality or access to medical services by clients.

The federal grantor requires that all waiver programs are cost effective or cost neutral, meaning that the savings are at least equal to or greater than the cost of the program. A calculation of the cost savings for the Healthy Connections program is performed each quarter by the federal grantor, based on financial and statistical data

provided by the Department. This calculation divides clients enrolled in the program into four Medicaid eligibility groups to reduce the effects of different eligibility criteria and utilization.

Based on the calculations provided by the federal grantor for fiscal year 2005, two of the four Medicaid eligibility groups have not been cost effective over the past three quarters, and a third group has not been cost effective in the most recent quarter. Although the program encourages providers to accept more Medicaid clients, it apparently does not result in a reduction in total Medicaid costs. The federal grantor may suspend the waiver, and could seek recovery of excess costs of operating the program.

RECOMMENDATION #6

We recommend that the Department reevaluate the Healthy Connections waiver and discontinue this program, or consider incorporating it into the State Plan to eliminate the need to justify cost effectiveness and eliminate the potential refund of program costs to the federal grantor.

CORRECTIVE ACTION PLAN

Idaho is undertaking a significant Medicaid reform effort, beginning in July 2006. Under the reform proposal, Idaho will break its current single State plan into three distinct State plans for the following three populations: 1) low-income children and working-aged adults; 2) individuals with disabilities and special needs; and 3) elders, including those who have Medicare coverage. Healthy Connections will no longer be segregated into a separate 1915(b) waiver, and will be incorporated into each of the three State plans under a section 1115 waiver along with other reform components. The 1115 waiver must meet federal budget neutrality requirements similar to cost-effectiveness tests for a 1915(b) waiver. The Healthy Connections program component will not maintain a separate cost-effectiveness test. Additionally, waiver budget neutrality is measured for the entire scope of the waiver for the duration of the waiver period. There is no risk of potential refund for any specific Medicaid Eligibility Group (MEG) or any specific quarter if the overall waiver scope for the entire waiver period meets the budget.

FINDING #7
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0405ID5028
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

Efforts by the Child Support program to recover Medicaid birth costs are not consistent.

The Medicaid program is responsible for pursuing all liable third parties for medical costs paid by the program. Part of this responsibility is assigned to the Child Support program to pursue non-custodial parents for birth costs paid by the Medicaid program.

The collection of birth costs by the Child Support program have increased steadily since this effort was re-established in January 2002, as shown in the following table:

Fiscal Year	Collections
FY 02	$642,298
FY 03	1,454,992
FY 04	2,585,492
FY 05	2,448,224

However, our limited tests showed that as many as one-third of all single-parent birth costs paid by Medicaid (6 of 19 cases tested) were not pursued by the Child Support program. Four of these cases did not have a child support case established, and two had a case established, but birth costs were not pursued or included in the court order.

It is the general practice of the Child Support program not to pursue birth costs from the biological father if he resides with or subsequently marries the mother. However, if the income and resources of the biological father are not considered when determining eligibility, then he is a third-party resource, as defined by Medicaid regulations, and must be pursued. The Child Support program may exclude cases from pursuit when such efforts would put the custodial parent at risk. However, no documentation was available to support the reasons for not pursuing birth costs or establishing a child support case.

As a result, we estimate that recoveries could increase by $500,000 or more annually, if child support cases were established and pursued in all instances involving birth costs of a single-parent Medicaid client.

RECOMMENDATION #7

We recommend that the Department pursue birth costs from all biological parents who are not included on the application for Medicaid assistance. Child support cases should be established for all clients, and the reasons for not pursuing birth costs documented, where appropriate.

CORRECTIVE ACTION PLAN

Medicaid has asked for and received guidance from CMS on the pursuit of birth costs from absent parents. Their guidance stated:

> . . . there is no federal requirements that states must collect birthing costs. Section 1902(a)(25)(A) of the Social Security Act (the Act) requires that states "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan." Federal regulations at 42 CFR 433.138, lay out some specific measures that states are required to pursue to determine legal liability . . . Other 'reasonable' measures are left up to the discretion of the state, such as whether or not to pursue birthing costs. . .
>
> While a few states have opted to pursue birthing costs, other states have viewed the collection of birthing costs as a deterrent to voluntary paternity establishment and therefore, serves to weaken the potential for developing strong relationships between fathers and their children. . .

Medicaid is reviewing this issue with program experts and the Deputy Attorney General's Office and will present options to the Director.

FINDING #8
CFDA Title: Child Support Enforcement
CFDA #: 93.563
Federal Award #: G0404ID4004
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:

The number of child support cases with debt errors has declined, but remains high.

Child support obligations are established by an order of the court and recorded in the Department's sophisticated computerized program known as the Idaho Child Support Enforcement System (ICSES).

Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

This system has features to record and accrue debt amounts, track collections, and distribute funds on multiple debts. Total debt balances on the nearly 82,000 open cases in the system, as of June 2005, were approximately $490 million.

We reported in a prior audit that more than 75% of child support debts pursued by the Department were the wrong amount or type of debt. Significant improvements have been made in the procedures to establish and adjust debts in ICSES, and several hundred cases are reviewed every month by a contractor to identify and correct debt errors. Review efforts have focused on cases where the client has complained, or the case worker has noticed a potential error in the debt balances. These improvements and focused reviews have reduced the number of cases with debt errors to approximately 20%, based on our current sample results.

However, this still represents more than 16,000 cases (20% of 82,000) where the Department is pursuing the wrong amount or type of debt. At the current volume of reviews performed each month, it will take more than ten years to work through all existing cases to identify and correct debt balance errors. The Department's request for additional funding to address this issue was not included in the Governor's recommendation in the fiscal year 2007 budget. In addition, changes in program requirements at the federal level will likely reduce grant funds in the coming year and place additional demands on State resources to meet program needs.

RECOMMENDATION #8

We recommend that the Department enhance the efforts to review and correct child support debts. The Department should continue to pursue additional resources to address this issue in order to complete this effort within a reasonable time frame, perhaps within the next two to three years.

CORRECTIVE ACTION PLAN

Child Support will continue working on improving the accuracy of debt balances by continuing to audit approximately 400 cases per month with the budget we have available. We requested an additional $3.1 million in FY 2006 that the legislature did not fund. We also requested an additional $3.1 million in FY 2007 that was not approved by the Governor.

We will also continue to improve our financial accuracy through the ongoing re-engineering of child support processes, with the focus on improving the quality of case management work. We will continue to enhance and clarify policies, make automated systems changes and consolidate and standardize practices with regard to setting up court orders, debts and financial adjustment activities.

FINDING #9
CFDA Title: Child Care and Development Block Grant
CFDA #: 93.596
Federal Award #: G0401IDCCDF
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency: Department of Health and Human Services
Compliance Requirement: Special Tests

Child care benefits are calculated on market rates and poverty tables that are more than five years old.

The Department's administrative rules for the Child Care Program (IDAPA 16.06.12) describe the methods for calculating benefits provided to clients. Benefits are based primarily on surveys of rates charged by child care providers and a sliding fee scale based on the federal poverty rate. Surveys are required at least every two years

Questioned Costs: Not determinable

(rule 305.01(d)), and the poverty rate is the established rate published annually in the federal register (rule 307.01). However, these key calculation components have not been updated for more than five years.

The current benefit calculation uses survey results as of January 1, 2001, and the sliding fee scale is based on federal poverty rates in effect through March 17, 1999. As a result, lower amounts of assistance are provided for those clients most in need, while excluding others whose income is less than current poverty amounts from receiving any assistance. This approach has limited the program growth with the unintended result of inhibiting access for the working poor and the potential success of the program.

The reason for using old market surveys and poverty rates is likely an intended method for managing the growth in program costs. However, this approach undermines the integrity of the administrative rules and related processes that ensure appropriate and equitable access to benefits.

RECOMMENDATION #9

We recommend that the Department base the child care benefit calculation on current market rate surveys and federal poverty rates, as required by administrative rule. Efforts to manage the growth in program costs should rely on appropriate processes to adjust administrative rules or other factors used to determine benefit amounts and client eligibility.

CORRECTIVE ACTION PLAN

The Department surveys market rates every two years, but is not required to adjust the market rate because of the survey. The Division disagrees that this rule requires poverty rates used for payment be based on the current federal register. IDAPA 307.01. refers to poverty rates as established annually in the federal register. The Idaho Child Care Program (ICCP) does not interpret this rule as a requirement to adjust the poverty limits annually. There is no federal mandate that the poverty limits are adjusted annually.

Bringing the poverty rate current in ICCP would result in an estimated increased expense of $2 million. Raising the market rate is an estimated increased expense of $1.5 million. This totals $3.5 million that is not available in ICCP budget.

There are currently a number of priorities under consideration to be balanced against the available ICCP budget. Raising the market rate and bringing the poverty limits current are being considered. The Division of Welfare takes the responsibility of serving ICCP customers very seriously. It is important that the limited money available be used to provide services to those who need it most.

FINDING #10

CFDA Title: Temporary Assistance to Needy Families (TANF)
CFDA #: 93.558
Federal Award #: G0401IDTANF
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Allowable Costs
Questioned Costs: $2,056 in medical costs;

TANF funds are used for medical costs, foster care services and other unallowable activities.

Federal funds under the Temporary Assistance to Needy Families (TANF) program are available for a variety of services to clients, and are distributed to several programs across multiple divisions within the Department. Costs are allowable if they directly meet one of four federal program purposes, or were specifically authorized under prior federal law and the Department's 1995 State Plan. Federal

other amounts not determinable

regulations prohibit the use of TANF funds for medical services.

We reported in the prior audit that TANF funds were used for medical costs and other unallowable services. Improvements in supervisory oversight and Department policies have been made over the past several years, reducing the number of questionable or unallowable expenditures. However, we continue to identify expenditures for various costs that are specifically unallowable, or for services to families with incomes that exceed established limits.

Medical services are charged to TANF in error.
Federal regulations and the Social Security Act (Title IV-A section 408(6)(A)) prohibit the use of TANF funds for any type of medical services. We identified $2,056 in orthodontic and other medical costs paid with TANF funds that are specifically not allowable.

Unallowable foster care costs were paid using TANF funds.
Foster care costs for children eligible under the Title IV-E Foster Care Grant cannot be paid with TANF funds.

Eligibility for Title IV-E foster care services must be completed within 30 days, as required by Department policy. However, the Department routinely uses TANF funds to pay all costs for the first 90 to 120 days for most new foster care cases, prior to charging other programs depending on a child's eligibility. As a result, TANF funds are used improperly to pay for services after a child's eligibility under the Title IV-E Foster Care Grant has been determined. The amount of unallowable costs is not readily determinable due to the many variables and conditions that exist.

The Department also uses TANF funds to pay foster care costs for children placed with a non-relative, as authorized under prior law and the State's 1995 State Plan. These costs must be reported separately in the federal quarterly grant reports. However, since the TANF program began in 1996, no amounts have ever been reported.

Emergency conditions beyond a family's control are not properly documented.
The State Plan allows the use of TANF funds to assist families if their income is at or below 200% of poverty, or they are unable to meet an "emergency condition" due to circumstances beyond their control. In several cases we reviewed, assistance was provided to families with incomes that exceeded 200% of poverty, and the documented circumstances did not indicate an emergency condition existed or that the events were beyond the families' control.

For example, nearly $6,000 in TANF funds was used to pay for a vinyl fence because the family's child was at risk of wandering away from home. The family owned and operated a business with income above 200% of poverty. These factors were known at the time of application, but a financial analysis was not prepared to identify the family's income or resources. Assistance was provided based on the

family's representation of their inability to resolve the emergency due to "circumstances beyond their control."

We question the conclusion that the child was in an "immediate danger of a life-threatening or emergency situation," or that the circumstances were beyond the family's control or financial resources. In addition, the purchase of a high-quality vinyl fence to enclose the family's entire yard does not appear to be the lowest cost option for resolving this situation.

RECOMMENDATION #10

We recommend that the Department review all foster care costs paid with TANF funds, in order to identify the amounts allowable under prior law, and amend the federal quarterly reports for the past year to accurately reflect the amounts. The Department should amend the current TANF State Plan to clarify the circumstances for which foster care costs are allowable, and develop new coding structure to properly report these costs in the future.

We also recommend that the Department reaffirm with staff, the requirements for documenting family income and emergency conditions when authorizing services using TANF funds, and return $2,056 to the federal grantor for medical costs charged to the TANF Grant in error.

CORRECTIVE ACTION PLAN

Response regarding medical services are charged to TANF in error: We concur that costs of $2,056 were charged to TANF in error, since they were clearly medical in nature. Upon receiving notice of this error, FACS [Family and Community Services] informed management in Region 7 and learned that the staff person involved has received correction.

The Statewide Emergency Assistance Management (SEAM) Team was informed of this error and will reinforce the exclusion for medical expenses in its training of current staff and new Navigator staff who will assume responsibility for TANF-funded emergency assistance in the next few months. FACS will adjust the transactions to a proper funding source and return the $2,056 to the TANF grant.

Response regarding unallowable foster care costs were paid using TANF funds: The FACS Division has charged foster care payments to TANF based on its invocation of the pre-existing 1993 State Plan which authorizes such. Attachment 3-A of this 1993 State Plan describes "Kinds of assistance provided to meet emergency situations" to include "foster family care, or residential care for children separated from their parents, including food, clothing, and supervision unless the child has such assistance provided under Title IV-E…."

The Department will amend its TANF State Plan to 1) cite its invocation of the pre-existing 1993 Plan as the authorization for charging foster and residential care to TANF, and 2) describe the circumstances for which foster care costs can be charged to the TANF grant.

The FACS Division will reinforce the need to switch funding for foster care promptly to sources other than TANF upon the establishment of eligibility for Title IV-E. Users of FOCUS [Family Oriented Community User System] (which processes TANF

payments for foster care) will make these adjustments as soon as they receive the automated alert that IV-E eligibility is established.

The FACS Division also asks for further clarification on the auditors' claim that "most costs in question do not meet the requirements described in the pre-existing State Plan."

Response regarding emergency conditions beyond a family's control are not properly documented: The Department concurs with this finding in that its own internal review process (conducted by the Local EA [emergency assistance] Management Team) independently found error in the EA application resulting in the purchase of a $6,000 vinyl fence. Department staff did not document the family's income or access to additional resources on the specified application budget sheet. Beyond this procedural error, the Department notes that staff did not exercise diligence in researching the availability of both lower-cost alternatives to the vinyl fence and financial resources otherwise accessible to the family.

This case was considered at the most recent SEAM meeting of March 8, 2006. SEAM members reaffirmed that budget documentation is required for making the income eligibility decision and that the State pursue the most economical responses to EA applications. SEAM will emphasize this in training to current staff and new Navigator staff, who will assume responsibility for Emergency Assistance applications on a statewide basis in the next few months.

FINDING #11

CFDA Title: Food Stamps Administration and Certification
CFDA #: 10.561
Federal Award #: 7ID400ID4
Program Year:
October 1, 2003 to September 30, 2004
Federal Agency:
Department of Health and Human Services
Compliance Requirement: Special Tests
Questioned Costs: Not determinable

Food stamp error rate continues to exceed the allowed percentage and will result in additional financial sanctions.

We reported in the fiscal year 2003 audit report that the food stamp error rate in Idaho had exceeded the allowed maximum for the past two years. This trend has not improved, and a financial sanction of $277,464 was imposed on the Department by the federal grantor for fiscal year 2004. A larger sanction is likely for fiscal year 2005.

Federal regulations (7 CFR 275) require states to limit the number of errors when determining food stamp benefits and eligibility. Errors are identified as either over- or under-payments, or "negative errors," which represent individuals who were improperly denied assistance. The maximum acceptable payment error rate, as set by the federal grantor, has declined steadily over the past several years, and is currently 5.88% for fiscal year 2005. States with an error rate greater than this may be sanctioned, while those with a lower payment error rate could receive additional funding.

The Department's payment error rate for fiscal year 2004 was 9.18%, which exceeded the allowable rate of 6.64% and resulted in a sanction of $277,464. Although the Department has reduced the error rate, as shown in the following table, it continues to exceed the allowed rate and will likely result in another sanction for fiscal year 2005. The amount of the sanction is not yet determined, but could exceed the prior year's amount based on the factors used by the federal grantor to calculate sanctions.

Year	Allowed Rate	Payment Error Rate	Sanction	Negative Error Rate
FFY 2002	8.26%	9.04%	$45,677	5.25%
FFY 2003	7.64%	11.31%	$0	10.05%
FFY 2004	6.64%	9.18%	$277,464	10.93%
FFY 2005	5.88%	8.23%	unknown	10.61%

Note: The sanction for federal fiscal year 2002 was waived, and no sanctions were imposed on any state for federal fiscal year 2003.

The negative error rate, which represents the percentage of clients who were denied benefits in error, has remained above 10% for the last three years. Although the federal grantor does not sanction states for this type of error, the effect is that nearly 3,000 families in Idaho were improperly denied assistance during 2005.

The Department received additional resources and staff during the fiscal year 2005 legislative session, which allowed reductions in case loads per worker, and improvements in the monitoring, review, and quality control functions. These efforts are reflected in the declining error rates. However, errors continue to occur beyond the allowed limits, due primarily to the outdated EPICS eligibility system used to record and process applications and benefits.

As mentioned earlier, EPICS was initially installed in the early 1980's and has undergone significant adjustments and modifications during the last 25 years. However, this system uses outdated technology with significant limitations and the inability to integrate with newer systems and Web-based applications. All of this combines into a situation where food stamp error rates will likely remain at unacceptable levels for the foreseeable future.

RECOMMENDATION #11

We continue to recommend that the Department improve the accuracy of the eligibility process to reduce payment errors and negative error rates, in order to avoid additional sanctions and the consequences to needy families who are denied assistance in error. A renewed effort to seek funding to replace the outdated EPICS eligibility system should be considered.

CORRECTIVE ACTION PLAN

The Corrective Action Plan to further reduce the error rate is a three-pronged approach.

1. To realize immediate results, the Division is reviewing all cases with benefits exceeding $300 prior to the release of these benefits. This activity was selected in FFY 2005, 41% of all errors were in cases with benefits exceeding $300. This activity is being funded by a reinvestment of the sanction.
2. To achieve mid- and long-term sustainable improvements, the Division is taking specific steps to reengineer the business processes and food stamp policy to improve the initial application and application for recertification functions.
3. The quality assurance data indicates that 60% of the errors occur in these two functions. To achieve long-term sustainable improvements, the Department now has funding and is reengineering and replacing the EPICS system.

FINDING #12

Fees for mental health services are based on poverty rates that are

State Issue

more than 13 years old.

Mental health services are provided to clients at the Department's regional offices as part of the Community Mental Health Services program. It is the Department's policy to charge fees to clients based on their ability to pay, as determined by a discount schedule shown in Administrative Rules, section 16.04.03. In addition, liable third-party sources, including private health insurance, Medicaid, and Medicare, must be included in developing a client's total ability to pay to maximize reimbursement for the cost of service provided.

Many of the fees charged for Community Mental Health Services have not been updated for years. For example, established fees for various diagnostic and treatment services listed in section 100.09 of the rules have not been adjusted since January 1994. The sliding-fee scale, shown in section 100.03, is based on federal poverty rates in effect as of February 12, 1993, more than 13 years ago.

The outdated fixed-fee amounts may result in some under-recovery of program costs. However, the outdated sliding fee scale results in clients paying a higher share of the costs in error.

RECOMMENDATION #12

We recommend that the Department adjust the fees listed in the Community Mental Health Services administrative rules to reflect current rates and federal poverty guidelines. We also recommend that the Department consider amending these rules to describe the method for determining the fees, rather than detailed values or fixed amounts, as a way to avoid the need for future amendments.

CORRECTIVE ACTION PLAN

The Department will seek to change the rule so that it describes the scale method and refers to the current federal poverty limits. The rule change will exclude the detailed fixed prices for services that are covered under Medicaid and make reference to the Medicaid fee schedule. The Department will also update all fees not addressed by Medicaid.

This rule change will require parallel changes in the "Fees for Developmental Disabilities Services" as they use the same poverty rates, sliding fee scale and billing system as the Adult Mental Health Program. There may also be an impact to the "Rules Governing Family and Children's Services" which identifies fees for children's mental health services and includes the use of a sliding fee scale, based on 1998 poverty rates.

FINDING #13

Administrative rules for recovering certain types of Medicaid costs from parents are not enforced.

State Issue

Administrative rules governing the Medical Assistance Program (section 16.03.09.031) identify the Department's intent to recover from a child's parents, all or part of the cost of certain types of Medicaid services to a child. These rules were developed in response to legislation passed in 1994, which included an appropriation to implement the Legislature's intent that the Department make and collect assessments on a sliding-fee scale from parents whose children are living in nursing homes, immediate care facilities for the mentally

retarded (ICF-MR), or receiving benefits under the Certain Disabled Children (Katie Beckett) Program. It was estimated that this action would save Medicaid $727,200 in fiscal year 1995. These rules were last amended on July 1, 1997.

Some parents of disabled children filed an action in Idaho's Fourth Judicial District Court. On February 25, 1998, the court ruled that the Department could not require parents to share in the cost of care for children in this program. This ruling was specific to the issues relating to recovery of costs for children in the Katie Beckett program. It did not specifically preclude the Department from pursuing the recovery of medical costs for services to children in nursing homes or ICF-MR .

We found no indication that the Department has taken steps to enforce these rules and collect amounts from parents, seek to amend or delete all or part of these rules, or appeal the District Court's decision relating to the recovery of costs within the Katie Beckett program. The Department's subsequent inaction concerning these requirements has resulted in missed opportunities to potentially recover millions in Medicaid costs from parents, as directed by the 1994 Legislature.

RECOMMENDATION #13

We recommend that the Department undertake a complete analysis of the legal and legislative requirements for recovering certain Medicaid costs from parents. This analysis should seek to resolve the issues of whether to amend or delete these rules, appeal the District Court's ruling, or request legislation to clarify the intentions or authority to recover these costs from parents.

CORRECTIVE ACTION PLAN

The Department has analyzed this issue in conjunction with the Deputy Attorney General. Our current rules are inconsistent with federal law and not enforceable as demonstrated by the District Court ruling. The Department plans to review the statutory, legal and administrative issues during the coming months to determine the appropriate resolution.

PRIOR FINDINGS AND RECOMMENDATIONS. The prior audit report covered fiscal year 2004 and included nine findings and recommendations. The following is the status of those findings and recommendations.

PRIOR FINDING #1

Contract monitoring efforts were inadequate, resulting in errors, omissions, and delays in recovering Medicaid costs from private insurance resources. We recommended that the Department immediately strengthen the contract performance requirements and monitoring efforts to improve the results of third-party insurance recovery efforts. These efforts should include developing processes to confirm that insurance resources are identified and recorded promptly, ensuring that all recoverable costs are pursued from the identified liable resources, and confirming that commissions paid to the contractor are based on collections resulting from the contractor's efforts. We also recommended that the Department evaluate all collections reported by the contractor since July 2002, in order to identify and recover any unearned fees.

STATUS: CLOSED

The Department had the existing contract reviewed by the State Attorney General's Office and concluded that the activities in question were within the scope of the contract. However, the practice of issuing amnesty letters has been suspended for the remainder of the existing contract, and the RFP for a new contract will clarify this activity.

A new process was implemented in September 2005 to ensure that all recoverable costs are identified and pursued, and a review of unearned commissions was completed by the Department's Internal Audit section. The current contract was amended to clarify the write-off criteria, and the accounts receivable balance was written down as of June 30, 2005.

PRIOR FINDING #2

The Department has not yet taken steps to pursue absent parents for reimbursement of ongoing Medicaid costs. We again recommended that the Department develop a strategy to pursue and recover Medicaid costs from absent parents. This strategy should include methods for identifying all absent parents, and opportunities to incorporate the Department's existing efforts and information in pursing these individuals.

STATUS: OPEN

The Department consulted with federal officials about the authority to designate an absent parent as a liable third-party resource, and is still waiting to receive guidance on this issue before any actions are taken.

PRIOR FINDING #3

Applications and redeterminations of Medicaid eligibility were not processed within the required time frames. We recommended that the Department develop a strategy to comply with the time frames and requirements for processing applications and redetermining eligibility for Medicaid. This strategy should include establishing a quality control review process to identify training and process issues and limitations in existing automation. The Department should also consider seeking additional resources and renewing its efforts to modify or develop automated processes to prevent or limit the opportunity for recurring eligibility errors.

STATUS: CLOSED

The Department agreed with this finding, and in April 2005 the Legislature granted authority to fill 35 new eligibility positions staggered over a one-year period. The Division of Welfare has filled all 26 positions made available to date, and will hire the remaining 9 positions when they become available in January 2006.

Of the 26 positions hired, 15 were allocated to improve general eligibility determinations and to reestablish the Quality Review Team to address the issues in this finding. The remaining 11 were allocated to improve CHIP eligibility determinations (see Prior Finding #4). In addition, the Department developed a Decision Unit to fund an improved eligibility system, which will be included in the fiscal year 2007 budget request.

PRIOR FINDING #4

Eligibility continues to be improperly determined in one-third of the Children's Health Insurance Program (CHIP) clients tested. We again recommended that the Department review case files and remove ineligible clients from CHIP. Additional resources and renewed efforts are also needed to develop new automated systems and processes to limit the opportunity for recurring eligibility errors.

We also recommended that the Department negotiate a resolution with the federal grantor concerning the potential refund for the cost of providing services to ineligible clients.

STATUS: OPEN

The Department agreed with this finding, and in April 2005 the Legislature granted authority to fill 35 new eligibility positions staggered over a one-year period. The Division of Welfare allocated and filled 11 of these positions to improve CHIP eligibility determinations. A Decision Unit was also developed in the fiscal year 2007 budget request to fund an improved eligibility system.

The questioned cost amount has not yet been resolved with the federal grantor.

PRIOR FINDING #5

Enforcement of administrative rules for Medicaid transportation providers needed improvement. We recommended that the Department enforce existing rules for non-emergency transportation providers. At a minimum, the Department should require that each provider submit copies of all drivers' licenses, vehicle registrations, and proofs of insurance as part of the annual provider agreement renewal process.

We also recommended that the Department consider amending existing rules to require transportation providers to supply documentation annually, showing background checks for all staff, and safety inspections of all vehicles.

STATUS: CLOSED

The Department increased the number of staff allocated to transportation management, and continues to conduct reviews of transportation claims. The existing rules and enforcement mechanisms were evaluated for any appropriate enhancements, and the Department plans to address the background check requirement of the finding during the 2007 session of the legislature.

PRIOR FINDING #6

No procedures exist to identify or pursue child support debts from the estates of deceased non-custodial parents. We recommended that the Department develop procedures for pursing child support debts from the estates of deceased non-custodial parents through probate or other means. The Department should consider combining these efforts with the existing estate and probate recovery activities in the Medicaid program.

STATUS: OPEN

The Department agrees with this finding, and the Divisions of Welfare and Medicaid are currently evaluating how best to coordinate estate and recovery activities.

PRIOR FINDING #7

Time frames were missed for providing services to interstate child support cases. We recommended that the Department develop a strategy to provide services to interstate child support cases within the required time frames. This strategy should include training that reinforces the time frame requirements for interstate cases, and methods to reduce caseloads, such as reallocating or seeking additional resources and staffing.

STATUS: CLOSED

The Department agreed with this finding, and received legislative authority for 15 new Child Support positions in April 2005. These positions allowed the Department to make improvements in the processes and realign the workload to reduce the delays in providing services.

PRIOR FINDING #8

The Department improperly used more than $1.8 million of the TANF grant funds for inpatient treatment costs and child-care services. We recommended that the Department comply with federal regulations by not charging medical services or child-care costs to the TANF grant. Program staff should be notified that residential treatment placements that include any medical services are not allowable costs in the TANF program.

We also recommended that the Department contact the federal grantor to resolve the questioned costs and potential refund of federal funds.

STATUS: OPEN

The Department is awaiting a final determination from the federal grantors as to whether inpatient costs and child-care costs were made in accordance with federal rules and State Plan. The Department will develop a process to ensure that direct TANF payments for child care are made to eligible families based on the information provided by the federal grantor.

PRIOR FINDING #9

Contracting for information technology (IT) services is not cost effective when compared with hiring State staff. We recommended that the Department reevaluate the IT programming and maintenance services contract and seek executive and legislative authority to replace contract personnel with state staff to reduce costs.

STATUS: CLOSED

The Information Technology Services Division is undergoing a restructure in which all units have been affected. The administrator and unit bureau chiefs are reviewing and determining those areas where contractor conversion to State staff will occur. The Department has reduced contractor positions by 20, hired 11 State staff, and anticipates additional adjustments to staffing and contractor positions once the restructure plans are finalized and implemented.

AGENCY RESPONSE. The Department has reviewed the report, and its response to the findings and recommendations is included in this report.

OTHER ISSUES. In addition to the findings and recommendations, we discussed other, less important issues which, if changed, would improve internal control, ensure compliance, or improve efficiency.

This letter is intended solely for the information and use of the Department of Health and Welfare and the Idaho Legislature, and is not intended to be, and should not be, used by anyone other than these specified parties.

We appreciate the cooperation and assistance given to us by the Department and its staff.

QUESTIONS CONCERNING THIS DOCUMENT SHOULD BE DIRECTED TO:
Ray Ineck, CGFM, Supervisor, Legislative Audits
Don Berg, CGFM, Managing Auditor

Report IC27005 / SA27005 / CA27005